

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Breast Reduction (Female)
<b>Case Number:</b> 0200202	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for breast reduction to relieve shoulder, neck, and back pain.	<b>Reason for Decision:</b> External review agency determined that there is no documented medical evidence of the alleged physical pain or irritation under or between the breasts and no evidence of conservative treatment for the pain and irritation.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Breast Reduction (Female)
<b>Case Number:</b> 0200215	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for reduction mammoplasty due to symptoms relating to fibrocystic breasts.	<b>Reason for Decision:</b> External review agency determined that reduction is not indicated for difficult mammographies and 220g removed from each breast is not a sufficient amount for medical necessity and is not a preventive measure for breast cancer.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Breast Reduction (Male)
<b>Case Number:</b> 0200217	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for reduction of one breast following the removal of a possibly cancerous cyst from the other.	<b>Reason for Decision:</b> External review agency determined that there is no documentation of medication use, endocrinological disorder, nipple discharge, liver dysfunction, obesity, trauma to the breast, or other major medical problems. There is no bodily function impaired by the cyst and therefore the procedure is cosmetic and not a covered benefit.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Laser Surgery
<b>Case Number:</b> 0200221	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for laser hair removal from face due to Polycystic Ovary Syndrome and Hirsutism.	<b>Reason for Decision:</b> External review agency determined that the patient's problem is not "a bodily function imposed as the result of a congenital defect, birth abnormality, traumatic injury, or covered surgical procedure." Therefore the procedure is cosmetic and not a covered benefit.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Rhinoplasty
<b>Case Number:</b> 0200259	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for rhinoplasty to treat pain on tip of nose which has been present since reconstructive surgery in 1974.	<b>Reason for Decision:</b> External review agency determined that there is documentation of or treatment for pain in the nasal tip. There is no mention of a deviated septum in the pre- or post-operative reports. It seems that the rhinoplasty was purely cosmetic.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Breast Reduction (Female)
<b>Case Number:</b> 0200261	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for breast reduction.	<b>Reason for Decision:</b> External review agency determined that the numerous entries for medical treatment are not related to macromastia. The amount of tissue to be removed is also far less than any known objective criteria for medical necessity in any medical or surgical literature.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Breast Reduction (Female)
<b>Case Number:</b> 0200265	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for bilateral breast reduction due to neck, back, and shoulder pain, rash under her breasts, and to relieve social stress due to size of breasts.	<b>Reason for Decision:</b> External review agency determined that the patient does not meet the medical criteria set by the health plan for coverage of this service. The patient also does not intend to have 600g removed from each breast which would be required in order to receive coverage.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Laser Surgery
<b>Case Number:</b> 0200273	<b>Appeal Decision:</b> Overturned
<b>Case Summary:</b> Patient requesting coverage for laser surgery to treat telangiectasia and rosacea on patient's face, neck, and chest.	<b>Reason for Decision:</b> External review agency determined that the telangiectasia and rosacea are causing a physical dysfunction and the patient has already gone through a trial of antibiotics. Laser treatment is appropriate at this stage.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Orthognathic Surgery
<b>Case Number:</b> 0200278	<b>Appeal Decision:</b> Partially Overturned
<b>Case Summary:</b> Patient requesting coverage for orthognathic surgery for treatment of TMJ disorder and condylosis. Also requesting coverage for genioplasty to correct an overbite.	<b>Reason for Decision:</b> External review agency determined that the orthognathic surgery is medically necessary to alleviate pain in chewing, headaches, and gastrointestinal symptoms and it should not be postponed pending the remote chance of "a late growth spurt." The genioplasty, however, is purely cosmetic and is not medically necessary.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Orthognathic Surgery
<b>Case Number:</b> 0200278	<b>Appeal Decision:</b> Partially Overturned
<b>Case Summary:</b> Patient requesting coverage for orthognathic surgery for treatment of TMJ disorder and condylosis. Also requesting coverage for genioplasty to correct an overbite.	<b>Reason for Decision:</b> External review agency determined that the orthognathic surgery is medically necessary to alleviate pain in chewing, headaches, and gastrointestinal symptoms and it should not be postponed pending the remote chance of “a late growth spurt.” The genioplasty, however, is purely cosmetic and is not medically necessary.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Breast Reduction (Female)
<b>Case Number:</b> 0200286	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for bilateral breast reduction mammoplasty.	<b>Reason for Decision:</b> External review agency determined that although the doctor’s note mentions neck, shoulder, and back pain, it does not address how this pain interferes with ADL’s and it does not mention any non-surgical treatment modalities which could have been attempted. Furthermore, the patient is not having more than 600g removed from each breast. Therefore, this patient is not eligible for coverage for this service.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Ear Reconstruction
<b>Case Number:</b> 0200368	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Insured requesting coverage for ear reconstruction for daughter with a congenital deformity.	<b>Reason for Decision:</b> External review agency determined that there is no evidence of a “severe debilitating” congenital deformity and no evidence of severe microtia. The criteria for coverage are not met and therefore this procedure would be primarily cosmetic and not a covered benefit.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Septoplasty
<b>Case Number:</b> 0200371	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for septorhinoplasty and dermis fat graft, pertaining to a cleft lip deformity.	<b>Reason for Decision:</b> External review agency determined that the rhinoplasty and dermis fat graft procedures do not restore a bodily function and are considered cosmetic procedures which are not covered benefits. However, the health plan appropriately covered for the septoplasty.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Breast Implants
<b>Case Number:</b> 0200376	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for plastic surgery to correct breast asymmetry after having a lump removed.	<b>Reason for Decision:</b> External review agency determined that the patient is clearly having this procedure done to improve symmetry between both breasts. This patient fails to meet the coverage criteria since her breast asymmetry is not greater than one full cup size.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> DIEP Flap Reconstruction
<b>Case Number:</b> 0200400	<b>Appeal Decision:</b> Overturned
<b>Case Summary:</b> Patient requesting coverage for prophylactic bilateral mastectomies with DIEP flap reconstruction with an out-of-plan provider.	<b>Reason for Decision:</b> External review agency determined that this is a most complex operation in breast reconstruction and requires a plastic surgeon skilled in microsurgery that has a high volume of experience in this particular flap design. The in-network plastic surgeons have limited experience and have admitted so to the patient. This procedure should be performed by a more experienced out-of-plan provider.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Breast Reduction (Female)
<b>Case Number:</b> 0200401	<b>Appeal Decision:</b> Overturned
<b>Case Summary:</b> Patient requesting coverage for bilateral breast reduction to alleviate neck and back pain.	<b>Reason for Decision:</b> External review agency determined that the patient has cervical rediculopathy related to macromastia, as did her primary care physician and two other examining doctors. Conservative methods of treatment were attempted unsuccessfully. In such cases, mammoplasty is considered medically necessary and a covered treatment irrespective of height/weight guidelines.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Breast Reduction (Female)
<b>Case Number:</b> 0200453	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for breast reduction to treat lower back pain due to spondylosis at the L5 vertebra and to avoid the risk of future degenerative disk disease.	<b>Reason for Decision:</b> External review agency determined that the amount of tissue to be removed from each breast does not meet the health plan's requirement. Also, there is no documented interference with daily living due to back pain or history of interigo or soft tissue infections. Mild breast enlargement cannot be expected to cause significant increase in the progression of the patient's degenerative disk disease secondary to spondilolisthesis.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Laser Surgery
<b>Case Number:</b> 0200498	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for laser surgery to remove a beckers nevus (birth mark) on her face.	<b>Reason for Decision:</b> External review agency determined that this type of congenital nevus has a very low to negligible risk of malignant conversion. There is also some risk of potentially making its appearance worse or of burn scar formation with this procedure. There is no medical necessity for its treatment at this present time.

<b>Appeal Type:</b> Cosmetic/Reconstructive	<b>Appeal Category:</b> Breast Reduction (Female)
<b>Case Number:</b> 00300510	<b>Appeal Decision:</b> Upheld
<b>Case Summary:</b> Patient requesting coverage for bilateral reduction mammoplasty due to shoulder indentations, neck and back pain, and discomfort.	<b>Reason for Decision:</b> External review agency determined that the amount of tissue to be removed from each breast does not meet the health plan's criteria. She has a normal breast size for most women of her mesomorphic height and weight. Lack of objective indications to support reduction mammoplasty clearly fall below any commonly recognized conditions for approval.